AMENDED IN SENATE JUNE 2, 2005

AMENDED IN SENATE MAY 12, 2005

AMENDED IN SENATE MARCH 31, 2005

SENATE BILL No. 750

Introduced by Senator Soto
(Coauthor: Senator Alquist)

February 22, 2005

An act to add Section 14066.5 to, and to add Article 2.93 (commencing with Section 14091.25) to Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 750, as amended, Soto. Medi-Cal: disease management.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Services, pursuant to which medical benefits are provided to public assistance recipients and certain other low-income persons.

Existing law requires the department to apply for a waiver of federal law to test the efficacy of providing a disease management benefit to beneficiaries under the Medi-Cal program, including, but not limited to, the use of evidence-based practice guidelines, supporting adherence to care plans, and providing patient education, monitoring, and healthy lifestyle changes.

This bill would ~~require~~ *authorize* the department*, within its existing budget,* to require any ~~health care plan~~ *Acute Long-Term Care Integration (ALTCI) contractor*, as a condition of the ~~plan's~~ *contractor's* readiness to serve seniors and persons with disabilities ~~under the Medi-Cal program~~ *in an ALTCI pilot project*, to develop

performance objectives, and a program related to wellness behaviors and disease management.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) Medi-Cal costs in California are rising dramatically.

(b) A large portion of these costs are attributable to complications from chronic diseases.

(c) Chronic diseases dramatically decrease the quality of life of their victims.

(d) California's aged, blind, and disabled Medi-Cal eligible population, comprised of approximately one million persons, account for nearly 25 percent of Medi-Cal costs and its members are prime candidates to receive the greatest benefits from disease management.

(e) In Florida a single condition disease management program operating in just the northern one-half of the state reduced health care costs for Florida's Medicaid program by $12.6 million in the first two years of the program, representing a 5.6 percent net savings.

(f) A February 25, 2004, Bulletin (SDML#04-002) from the federal Centers for Medicare and Medicaid Services (CMS) to all state Medicaid directors encouraged states to take advantage of disease management in their Medicaid programs, offered technical assistance, and explained how they could draw down federal dollars for these programs.

(g) Many other states are basing health care plan readiness to serve seniors and persons with disabilities on the provision of disease management services.

(h) California has not actively pursued this type of innovative opportunity to use federal funds to aid Californians.

(i) Medi-Cal beneficiaries and California taxpayers will continue to be shortchanged if the State Department of Health Services does not begin to aggressively pursue these opportunities to provide effective disease management programs and services to dually eligible Medi-Cal patients.

(j) Acute and Long-Term Care Integration pilot projects are proposed for three California counties.

(k) Medi-Cal recipients who receive their care through those three projects should be ensured better care through the provision of appropriate disease management services.

SEC. 2. Section 14066.5 is added to the Welfare and Institutions Code, to read:

14066.5. As used in this chapter:

(a) "Disease management organization" has the same meaning as in Section 1399.900 of the Health and Safety Code.

(b) "Disease management programs and services" has the same meaning as in Section 1399.901 of the Health and Safety Code.

SEC. 3. Article 2.93 (commencing with Section 14091.25) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 2.93. Disease Management *for Acute and Long-Term Care Integration (ALTCI)*

14091.25. (a) It is the policy of the state to provide and encourage the provision of disease management programs and services. The department ~~shall~~ *may* implement this policy by developing a strategy for providing Medi-Cal beneficiaries who are also eligible for Medicare ~~with~~ *and enrolled in an Acute and Long-term Care Integration (ALTCI) project with appropriate* disease management programs and services that improve patient outcomes and reduce health care costs.

(b) Any disease management organization providing disease management programs and services under this article shall possess full patient and practitioner oriented accreditation in the provision of those disease management programs or services by one or more nationally recognized health care accrediting organizations, including, but not limited to, the National Committee for Quality Assurance, the Joint Commission on Accreditation of Health Care Organizations, and the American Accreditation Health Care Commission.

(c) In order to ensure that the preventive aspects of disease management programs and services reach the greatest number of

people, disease management programs provided under this article shall be population based.

(d) A disease management program adopted or implemented under this section shall be designed to support and improve the physician-patient relationship.

(e) The department ~~shall require any health care plan, as a condition of the plan's readiness to serve seniors and persons with disabilities under the Medi-Cal program, to comply with all of the following requirements:~~*, within its existing budget, may require any ALTCI contractor, as a condition of the contractor's readiness to serve seniors and persons with disabilities participating in an ALTCI pilot project, to comply with any one or combination of the following conditions:*

(1) Develop performance objectives to encourage wellness behaviors or minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional and long-term care and the inappropriate or unnecessary utilization of high-cost services.

(2) Provide a wellness or disease management program for certain Medicaid recipients participating in the waiver. At a minimum, the department shall ~~require~~ *consider requiring* a plan to develop a disease management program for recipients who have, or have been diagnosed with, any *one or combination* of the following conditions:

(A) Diabetes.
(B) Asthma.
(C) HIV/AIDS.
(D) Hemophilia.
(E) End stage renal disease.
(F) Congestive heart failure.
(G) Chronic obstructive pulmonary disease.
(H) Autoimmune disorders.
(I) Obesity.
(J) Smoking.
(K) Hypertension.
(L) Coronary artery disease.
(M) Chronic kidney disease.
(N) Chronic pain.

(3) Develop disease management protocols for care and provide oversight to ensure that the service network provides ~~the~~ *any* contractually agreed-upon level of services.

(f) Subject to paragraph (3) of subdivision (e), the department may require a health care plan to develop appropriate disease management protocols, develop procedures for implementing those protocols, and determine the manner in which disease management shall be provided to plan enrollees. The department may allow a plan to contract separately with another entity for disease management services or provide disease management services directly through the plan.

(g) The department may establish either or both of the following:

(1) Performance contracts that reward a plan when measurable operational targets in both participation and clinical outcomes are reached or exceeded by the plan.

(2) Performance contracts that penalize a plan when measurable operational targets in both participation and clinical outcomes are not reached by the plan.

(h) The department shall develop oversight requirements and procedures to ensure that plans subject to this section utilize standardized methods and clinical protocols for determining compliance with a wellness or disease management plan.

(i) If the department implements a performance contract described in paragraph (1) of subdivision (g), the plan shall negotiate with participating physicians to achieve the operational targets.

(j) Nothing in this section shall be construed to limit a physician's ability to use his or her professional judgment in developing the patient's treatment plan.

(k) Any disease management program implemented or adopted under this section shall not result in a net increase in costs to the Medi-Cal program for implementing Acute Long-Term Care Integration pilot projects.

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